emailed validation letter 12/29/11

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 12.5.11
Amount #240.00

Ck# 352828

I. IDENTIFICATION

Name: T. J. Samson Community Hospital Skilled Nursing Unit

Address: 1301 North Race Street

City/County/Zip: Glasgow Barren County 42141

Telephone number: wmoore@tjsamson.org

Administrator: Wendy Moore RN, MSN, LNHA

Date facility operation began at current address: _____

Date facility began operation under current owner: same

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled	0	0
Nursing Home	0	0
Nursing Facility	16	16
Intermediate Care	0	0
ICF/MR	0	0
Personal Care	0	0

II. CONTROL (check one in each column)

State
County
(City)
Private

Profit
(Nonprofit)

(Individual)
Partnership
Corporation

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

TJSCH
1301 North Race Street
Glasgow, KY 42141

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OFFICE OF INSPECTOR GENERAL

(OVER)

12/31

If facility owned or leased by a corporation, complete the following:

Name of corporation _____

Address of corporation _____

President or Chairman _____

Vice President _____

Secretary _____

Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
_____	_____
_____	_____
_____	_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Brenda J Moore, RN, MSN, LNHA — Signature of authorized representative

Admin — Title

11-28-11 — Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)